STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155605	A. BUILDING 00 B. WING	06/23/2011

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GRANDVIEW HEALTH & REHABILITATION CENTER	1959 E COLUMBUS ST MARTINSVILLE, IN46151

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F0000	This visit was for the Investigation of Complaint IN00092324. Complaint IN00092324-Substantiated, federal/state deficiencies related to the allegation are cited at F225 and F226. Survey dates: June 22 & 23, 2011 Facility number: 000400 Provider number: 155605 AIM number: 100266880 Survey team: Joyce Hofmann, RN Census bed type: SNF: 8 SNF/NF: 56 Total: 64 Census payor type: Medicare: 13 Medicaid: 44 Other: 7 Total: 64 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forthon the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.We are requesting paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on June 27, 2011 by Bev Faulkner,RN			
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on observation, interview, and record review, the facility failed to ensure a Qualified Medication Aide [QMA #1] immediately reported an allegation of sexual misconduct between a resident (Resident B) and an employee (LPN #1) of the facility. [QMA #1, Resident #B, and LPN #1]. Findings include: In interview with the Assistant Director of Nursing [ADoN] on initial tour of the facility on 06/22/2011 at 10 a.m., the ADoN indicated Resident #B was a young resident, only 44 years old, was independent with ambulation and activities of daily living [ADL's], had anger behaviors toward staff and others, was a little OCD [Obsessive Compulsive Disorder], jokes inappropriately, does like to touch others, but had no history of sexually acting out. Review of Resident #B's clinical record on 06/22/2011 at 12:50 p.m., indicated the resident was admitted to the facility on 08/26/2010 and had diagnoses which included, but were not limited to, Wernicke Korsakoff syndrome, [Wenicke's encephalopathy -encephalopathy associated with thiamine deficiency. Usually associated with chronic alcoholism, gastric carcinoma, or	F0225	1. Resident B was not harmed and was determined by a psychologist to be competent to make decisions for himself. Further, he stated he was a "willing participant." He was monitored with one-on-one visits by social services staff and showed no signs of mental anguish. Both QMA #1 and LPN #1 were suspended immediately once the facility administration became aware of the events and were terminated upon completion of the investigation. LPN #1 was reported by the facility to Licensure Board and the incident was seld-reported by the facility to ISDH in an effort to ensure the CNA/QMA Registry would be made aware of the incident, potentially resulting in action against QMA #1.2. All residents have the potential to be affected. Alert and oriented residents were interviewed regarding abuse and staff treatment of residents with no negative findings and non-interviewable residents were assessed from head to toe to ensure no signs of abuse were evident. See below for corrective measures.3. The policy and procedures regarding resident abuse were reviewed and no changes were indicated. Immediate re-education with staff from all departments was implemented and completed. The Social Services Director or her designee will interview five (5) residents weekly for four (4)	07/08/2011

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	hyperemesis gravidarum, loss of memory and disorientation with confabulation. Korsadoff's syndrome - personality characterized by a psychosis with polyneuritis, disorientation, muttering delirium, insomnia, illusions, and hallucinations. Painful extremities, rarely a bilateral wrist drop, more frequently bilateral foot drop with pain or pressure over the long nerves. May occur as a sequel to chronic alcoholism.], alcohol-induced mental disorder/persisting dementia, non-organic psychosis, thiamine and niacin deficiency, vitamin B12 deficiency, alcohol dependence syndrome, alcohol abuse, hyponatremia, anemia, depressive disorder, anxiety, hypertension, arthritis, insomnia, and constipation. Interview with QMA #1 on 06/23/2011 at 1:38 p.m., indicated a couple of months ago, Resident #B told her LPN #1 and he had sex. QMA #1 indicated at first she did not believe him and let it go for awhile. QMA #1 indicated of couple weeks after that she asked LPN #1 about the incident and she had told her they had no physical contact - "He couldn't get it aroused." QMA #1 indicated they were off the clock when LPN #1 told her about this and indicated to her it happened once and was not going to happen again. QMA #1 indicated the resident was still texting		weeks, then monthly for two (2) months, then quarterly thereafter. The Administrator or her designee will interview five (5) staff members weekly for four (4) weeks, then monthly for two (2) months, then quarterly thereafter. (see attachment A). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 8, 2011.	

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	her about a month ago or less and he would get irate if she ignored the text. Interview with LPN #1 on 06/22/2011 at 3:45 p.m., indicated Resident #B kissed her at work. LPN #1 indicated she was nice to him, did not feel like she had lead him on to think she wanted a relationship. LPN #1 indicated the kissing happened once and she had no sexual contact with Resident #B. LPN #1 explained Resident #B would come up in the hall and "put his around me." LPN #1 indicated the resident started texting her in March a lot, but was not personal texts. LPN #1 indicated for the past month she did not go into his room and she tried to avoid him. LPN #1 indicated she was sorry it happened and it was an error in judgment. LPN #1 indicated she told only LPN #2 about the incident. LPN #1 indicated she did get suspended pending investigation and was terminated from the facility. Observation of Resident #B was made on 06/22/2011 at 3:20 p.m. Resident #B was observed to be appropriately dressed, neat and clean in appearance, and was obviously younger than most of the residents in the facility. Interview with Resident #B at this time indicated he had been treated with dignity and respect during his stay at the facility. Resident #B indicated he knew LPN #1 and she mostly			

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	worked days, some evenings and some nights. Resident #B indicated his relationship with LPN #1 started out as her being his nurse and talking. Resident #B indicated LPN #1 never initiated anything that went on between her and himself. Resident #B indicated he did not feel sexually abused. "Absolutely not." was his reply. Resident #B indicated he and LPN #1 had sex on numerous occasions and had oral sex. Resident #B indicated LPN #1 was a good nurse and did her job very well. Resident #B indicated there were no other staff in which he was involved with in a relationship. Review of a written statement by LPN #2, dated 06/17/2011, indicated, "I was approached 2-3 wks [weeks] ago about QMA#1 and LPN #1 texting Resident #B. LPN #1 said that they had been texting along time but nothing sexual. She said sometimes he can be inapropriate [sic]. From that day on she ignored his text is what she told me, but he continues to text LPN #1. People on the floor (nurses) have mentioned him verbalizing having sex with 2 employees. On June 15, 2011, I was talking with LPN #1 and she told me she was sorry for lying to me but that she had had sexual contact with Resident #B. Not sexual intercourse but contact. I spoke with DON the following day, June			

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	16, 2011 around 8 p.m." The facility's Incident Report, dated 06/16/2011 at 7:30 p.m., indicated QMA #1 was also involved, in that she was aware of the relationship. The follow up incident report, dated 06/16/2011, indicated QMA #1 was terminated from employment as she was knowledgeable of the inappropriate relationship and did not report it to the facility administration. QMA #1 was questioned by staff on 06/17/2011 during the investigation and indicated she did know LPN #1 had kissed Resident #B and she did not tell anyone as she thought the management were all aware. QMA #1 indicated this incident happened awhile back when she was off for surgery which was in December. When asked why didn't she tell management about the incident, QMA #1 responded, "I don't know." The facility's policy on Reporting Alleged Abuse Social Service Interventions, dated February 2006, indicated, "All allegations of abuse, neglect or mistreatment will be reported directly to the Administrator or appointed designee and a thorough investigation will be completed. Procedures 1. Upon occurrence, the Administrator or his/her designee is to be immediately informed...."			

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	The facility's Abuse Prohibition, Reporting and Investigation Policy and Procedure dated January 2006 indicated, "... All reports of abuse must be reported to the Administrator immediately ... within 24 hours of the reporting or discovery of the incident. ... It is the responsibility of every employee of Hoosier Enterprises to not only report abuse situations, but also suspicion of abuse and unusual observations and/or circumstances, to his/her supervisor. If it is the employee's supervisor the employee is reporting, the employee must notify another facility supervisor or the facility Administrator. This Federal tag relates to Complaint IN00092324. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure staff did not cross the line of professional conduct between a resident and staff member and failed to have staff	F0226	1. Resident B was not harmed and was determined by a psychologist to be competent to make decisions for himself. Further, he stated he was a "willing participant." He was monitored with one-on-one visits	07/08/2011

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	immediately report all alleged violations immediately to administrative management for 1 of 3 residents reviewed for reporting of incidents and behaviors. [Resident #B, QMA #1, and LPN #1] Findings include: In interview with the Assistant Director of Nursing [ADoN] on initial tour of the facility on 06/22/2011 at 10 a.m., the ADoN indicated Resident #B was a young resident, only 44 years old, was independent with ambulation and activities of daily living [ADL's], had anger behaviors toward staff and others, was a little OCD [Obsessive Compulsive Disorder], jokes inappropriately, does like to touch others, but had no history of sexually acting out. Review of Resident #B's clinical record on 06/22/2011 at 12:50 p.m., indicated the resident was admitted to the facility on 08/26/2010 and had diagnoses which included, but were not limited to, Wernicke Korsakoff syndrome, [Wenicke's encephalopathy -encephalopathy associated with thiamine deficiency. Usually associated with chronic alcoholism, gastric carcinoma, or hyperemesis gravidarum, loss of memory and disorientation with confabulation. Korsadoff's syndrome - personality		by social services staff and showed no signs of mental anguish. Both QMA #1 and LPN #1 were suspended immediately once the facility administration became aware of the events and were terminated upon completion of the investigation. LPN #1 was reported by the facility to Licensure Board and the incident was seld-reported by the facility to ISDH in an effort to ensure the CNA/QMA Registry would be made aware of the incident, potentially resulting in action against QMA #1.2. All residents have the potential to be affected. Alert and oriented residents were interviewed regarding abuse and staff treatment of residents with no negative findings and non-interviewable residents were assessed from head to toe to ensure no signs of abuse were evident. See below for corrective measures.3. The policy and procedures regarding resident abuse and codes of conduct were reviewed and no changes were indicated. Immediate re-education with staff from all departments was implemented and completed. The Social Services Director or her designee will interview five (5) residents weekly for four (4) weeks, then monthly for two (2) months, then quarterly thereafter. The Administrator or her designee will interview five (5) staff members weekly for four (4) weeks, then monthly for two (2) months, then	

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	characterized by a psychosis with polyneuritis, disorientation, muttering delirium, insomnia, illusions, and hallucinations. Painful extremities, rarely a bilateral wrist drop, more frequently bilateral foot drop with pain or pressure over the long nerves. May occur as a sequel to chronic alcoholism.], alcohol-induced mental disorder/persisting dementia, non-organic psychosis, thiamine and niacin deficiency, vitamin B12 deficiency, alcohol dependence syndrome, alcohol abuse, hyponatremia, anemia, depressive disorder, anxiety, hypertension, arthritis, insomnia, and constipation. Interview with QMA #1 on 06/23/2011 at 1:38 p.m., indicated a couple of months ago, Resident #B told her LPN #1 and he had sex. QMA #1 indicated at first she did not believe him and let it go for awhile. QMA #1 indicated a couple weeks after that she asked LPN #1 about the incident and she had told her they had no physical contact - "He couldn't get it aroused." QMA #1 indicated they were off the clock when LPN #1 told her about this and indicated to her it happened once and was not going to happen again. QMA #1 indicated the resident was still texting her about a month ago or less and he would get irate if she ignored the text.		quarterly thereafter. (see attachment A). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 8, 2011.	

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	The facility's Incident Report, dated 06/16/2011 at 7:30 p.m., indicated QMA #1 was also involved, in that she was aware of the relationship. The follow up incident report, dated 06/16/2011, indicated QMA #1 was terminated from employment as she was knowledgeable of the inappropriate relationship and did not report it to the facility administration. QMA #1 was questioned by staff on 06/17/2011 during the investigation and indicated she did know LPN #1 had kissed Resident #B and she did not tell anyone as she thought management were all aware. QMA #1 indicated this incident happened awhile back when she was off for surgery which was in December. When asked why didn't she tell management about the incident, QMA #1 responded, "I don't know." Interview with LPN #1 on 06/22/2011 at 3:45 p.m., indicated Resident #B kissed her at work. LPN #1 indicated she was nice to him, did not feel like she had lead him on to think she wanted a relationship. LPN #1 indicated the kissing happened once and she had no sexual contact with Resident #B. LPN #1 explained Resident #B would come up in the hall and "put his around me." LPN #1 indicated the resident started texting her in March a lot, but was not personal texts. LPN #1			

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	indicated for the past month she did not go into his room and she tried to avoid him. LPN #1 indicated she was sorry it happened and it was an error in judgment. LPN #1 indicated she told only LPN #2 about the incident. LPN #1 indicated she did get suspended pending investigation and was terminated from the facility. Observation of Resident #B was made on 06/22/2011 at 3:20 p.m. Resident #B was observed to be appropriately dressed, neat and clean in appearance, and was obviously younger than most of the residents in the facility. Interview with Resident #B at this time, indicated he had been treated with dignity and respect during his stay at the facility. Resident #B indicated he knew LPN #1 and she mostly worked days, some evenings and some nights. Resident #B indicated his relationship with LPN #1 started out as her being his nurse and talking. Resident #B indicated LPN #1 never initiated anything that went on between her and himself. Resident #B indicated he did not feel sexually abused - "Absolutely not." was his reply. Resident #B indicated he and LPN #1 had sex on numerous occasions and had oral sex. Resident #B indicated LPN #1 was a good nurse and did her job very well. Resident #B indicated there were no other staff in which he was involved with in a			

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	relationship. Review of a written statement by LPN #2, dated 06/17/2011, indicated, "I was approached 2-3 wks [weeks] ago about QMA#1 and LPN #1 texting Resident #B. LPN #1 said that they had been texting along time but nothing sexual. She said sometimes he can be inapropriate [sic]. From that day on she ignored his text is what she told me, but he continues to text LPN #1. People on the floor (nurses) have mentioned him verbalizing having sex with 2 employees. On June 15, 2011, I was talking with LPN #1 and she told me she was sorry for lying to me but that she had had sexual contact with Resident #B. Not sexual intercourse but contact. I spoke with DON the following day June 16, 2011 around 8 p.m." The facility's policy on Reporting Alleged Abuse Social Service Interventions, dated February 2006, indicated, "All allegations of abuse, neglect or mistreatment will be reported directly to the Administrator or appointed designee and a thorough investigation will be completed. Procedures 1. Upon occurrence, the Administrator or his/her designee is to be immediately informed...." The facility's Abuse Prohibition, Reporting and Investigation Policy and			

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	Procedure, dated January 2006, indicated, "... All reports of abuse must be reported to the Administrator immediately ... within 24 hours of the reporting or discovery of the incident. ... It is the responsibility of every employee of Hoosier Enterprises to not only report abuse situations, but also suspicion of abuse and unusual observations and/or circumstances, to his/her supervisor. If it is the employee's supervisor the employee is reporting, the employee must notify another facility supervisor or the facility Administrator." The psychologist completed an exam on Resident #B on 06/17/2011 and determined Resident #B was competent to make his own decisions. Resident #B affirmed to the psychologist that there was a sexual relationship with LPN #1. The facility's employee handbook with revised date of November 2010 indicated, "... We expect all employees to follow our established policies, procedures, and rules and to act in a professional manner at all times...." The handbook had examples of impermissible conduct which included, but was not limited to, "Failure to report a resident/employee accident/injury/incident. ... or otherwise engaging in conduct that does not support Grandview's goals and objectives.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155605	A. BUILDING 00 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH & REHABILITATION CENTER	1959 E COLUMBUS ST MARTINSVILLE, IN46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	....Failing to comply with local, state, and federal laws and/or regulations or failing to report such non-compliance...." This Federal tag relates to Complaint IN00092324. 3.1-28(a)			